MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH ★

0741 (355)

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Week
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Walnut Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Quince Ashburn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rebecca Elizabeth Ashburn
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 10 1874

8. AGE: Years: 71 | Months: 6 | Days: 0 | If less than one day: hrs. min.

9. Birthplace: Myrtle-Nassemond-Virginia (town, county, and state)
10. Usual occupation: Lumberman
11. Industry or business: Lumber & Mill Work Co.

FATHER
12. Name: Henry Ashburn
13. Birthplace: Myrtle, Virginia

MOTHER
14. Maiden name: Elvira Gardner
15. Birthplace: South Hampton County Va.

16. Informant: Mrs. Norman Polk
Address: Pocomoke City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13 1945 (month) (day) (year)
Cemetery or crematory: Presbyterian Cemetery
Location: Pocomoke City, Md.

18. Funeral director: H. Harvey Bradshaw
Address: Pocomoke City Md

19. July 12 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1945 at 7.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Myocardial degeneration of heart	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam. M. D. or other
Address: Snow Hill Md Date signed 7/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07408

Reg. Dist. No. 353

1. PLACE OF DEATH:
County: Worcester
City or town: Bishopville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Bishopville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William J. Bunting

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Vilena Bunting
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct 6, 1867

8. AGE:

Years	Months	Days	If less than one day
77	9	23	hrs. min.

9. Birthplace: Bishopville Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming
FATHER 12. Name: Elisha Bunting
13. Birthplace: Md.
MOTHER 14. Maiden name: Nancy Selby
15. Birthplace: Md.
16. Informant: Mrs. Vilena Bunting
Address: Bishop. Md R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 1, 1945 (month) (day) (year)
Cemetery or crematory: I.O.O.F.
Location: Bishopville, Md.
16. Funeral director: McPaska Watson
Address: Selbyville, Del.
19. 7/31/45 (Date rec'd by registrar) Mrs Roy Burg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 19 45 at 1:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19 45, to July 29 19 45 and that I last saw h. alive on July 29 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. E. James M. D. or other
Address: Selbyville, Del. Date signed: 7-30-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

07499

★ Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about ten days

Hospital, institution, or street address where death occurred: not

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Worcester

City or town: Ocean City md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: World War No 1

3. (a) FULL NAME: James Dolling Cherry

3. (b) Social Security Number: yes not found

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	married

6.(b) Name of husband or wife: Louise Cherry (Not known) yes 6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 4 1891

8. AGE:

Years	Months	Days	If less than one day
54	—	14	..... hrs. ..... min.

9. Birthplace: Fairfax Co. Va. (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: Same as above

FATHER 12. Name: David Cherry

FATHER 13. Birthplace: Fairfax Co. Va.

MOTHER 14. Maiden name: Madaline Ellis Cherry

MOTHER 15. Birthplace: Fairfax Co. Va.

16. Informant: Louise Cherry

Address: Ocean City

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21 - 1945 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. 7-19 (Date rec'd by registrar) 19 45 Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1945 at 7 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1945 to July 18 1945

and that I last saw him alive on July 18 1945

	DURATION
Immediate cause of death: Cerebral Apoplexy	Unknown
Due to:	
Due to:	
Other conditions: Severe malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Kenneth L. Bowers M.D. M. D. or other

Address: Ocean City, Md. Date signed July 19, 1945

07410

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

CERTIFICATE OF DEATH

Reg. Dist. No. 354

VS A15 — MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Worcester
City or town: near Snow Hill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: near Snow Hill Md (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Boley Dashiell
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: Col'd
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: –
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): July 29 45

8. AGE:

Years	Months	Days	If less than one day
0	0	0	3 hrs. ... min.

9. Birthplace: near Snow Hill Md (Town, county, and state)
10. Usual occupation: –
11. Industry or business: –

FATHER
12. Name: Edward T. Dashiell
13. Birthplace: Snow Hill Md

MOTHER
14. Maiden name: Francis Dennis
15. Birthplace: Snow Hill Md

16. Informant: Edward T. Dashiell
Address: Snow Hill Md RR #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30, 1945 (month) (day) (year)
Cemetery or crematory: Sant John Holder
Location: Snow Hill
18. Funeral director: Irvin Bennett
Address: Stockton Md
19. June 29 1945 (Date rec'd by registrar) Mary McTaylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1945 at 9.40 a.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death: Do not know cause of death. It lived only 3 hours was living
Due to: when born and never cried.
Due to:
Other conditions (Include pregnancy within 3 months of death)

DURATION: –

Major findings of operations:
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam. M. D. or other
Address: Snow Hill Md Date signed: 7/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

07411

CERTIFICATE OF DEATH

★ Reg. Diat. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: near Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: near ~~Berlin~~ 7 Ocean City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Howard Derrickson

3. (b) Social Security Number: 215-14-3846 Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Married no

6.(b) Name of husband or wife: no
6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Nov 18 1902

8. AGE: Years	Months	Days	If less than one day
43	7	15	hrs. min.

9. Birthplace: Sycamore pt md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above

FATHER
12. Name: Edward J. Derrickson
13. Birthplace: Sycamore pt md

MOTHER
14. Maiden name: Phyllis Davis
15. Birthplace: Sycamore pt md

16. Informant: Mrs. Derrickson
Address: Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7 1945 (month) (day) (year)
Cemetery or crematory: Evergreen 7-7-1945
Location: Berlin md
18. Funeral director: James E. Stewart
Address: Salisbury md

19. 7-7-1945 (Date rec'd by registrar) Helen S. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19..., to — 19...
and that I last saw h... alive on — 19...

Immediate cause of death	DURATION
Myocardial degeneration	Instant
Due to: of heart	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work? No

23. SIGNATURE: John L. Riley D.P.S. Med Exam M. D. or other
Address: Snow Hill Md Date signed 7/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (548)

07412

CERTIFICATE OF DEATH

★ Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Wicomico
City or town: Newark Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Newark Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Earl Thayer Brudley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 19 1926

8. AGE: Years	Months	Days	If less than one day
20	5	4	hrs. min.

9. Birthplace: Newark Worcester Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Earl G. Brudley
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Bertie A. Mitchell
15. Birthplace: Maryland

16. Informant: Mr. Earl G. Brudley
Address: Newark Md Rural #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 26 45
(month) (day) (year)
Cemetery or crematory: Bates Methodist
Location: Snow Hill Md

18. Funeral director: Pearsall & Timmis
Address: Snow Hill Md

19. 7/25 45 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1945 at 6.46 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2/1/45 19 to 7/23/45 19 and that I last saw h alive on 7/23/45 19

Immediate cause of death	DURATION
Malignant Tumor of Brain	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen, M.D.
M. D. or other
Address: Snow Hill Date signed 7/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

07413

★ Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) R 10
2.(a) If veteran, name war

3.(a) FULL NAME John James Freeman

3.(b) Social Security Number 216-20-0048 A

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Ella M. Freeman
6.(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): Sept. 29 - 1850
8. AGE: Years: 94 Months: 9 Days: 23 If less than one day: hrs. min.
9. Birthplace: Berlin Worcester MD (Town, county, and state)
10. Usual occupation: Tailor
11. Industry or business:
FATHER 12. Name: William Freeman
13. Birthplace: Maryland
MOTHER 14. Maiden name: Rebecca Hudson
15. Birthplace: Maryland
16. Informant: Mrs. Ella M. Freeman
Address: Snow Hill, MD
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 24/45 (month) (day) (year)
Cemetery or crematory: Whatcoat
Location: Snow Hill MD
18. Funeral director: Kearney & Bunting
Address: Snow Hill MD
19. 7-24 (Date rec'd by registrar) 1945 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1945, at 2 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Carcinoma of	
Due to: face	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas R Law M. D. or other
Address: Berlin Md Date signed 7-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

07414

★ Reg. Diat. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: RURAL, Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: RURAL, Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: # R.F.D. 3

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Jane Hancock Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Obed A. Jones

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 25, 1860

8. AGE: Years: 85 | Months: 0 | Days: 25 | If less than one day: ____ hrs. ____ min.

9. Birthplace: RURAL, Pocomoke-Worcester-Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: James T. Hancock

13. Birthplace: Near Pocomoke City, Md

MOTHER — 14. Maiden name: Louisa Callahan

15. Birthplace: Near Pocomoke City, Md

16. Informant: Mrs. Samuel Smith

Address: R.F.D. 3, Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 20, 1945 (month) (day) (year)

Cemetery or crematory: Pilgrim Cemetery

Location: Near Pocomoke City, Md.

18. Funeral director: A. Harper Bradshaw

Address: Pocomoke City, Md

19. July 18, 1945 (Date rec'd by registrar) Ann E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17, 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945 to July 17, 1945

and that I last saw h[illegible] alive on July 16, 1945

Immediate cause of death: Myocardial degeneration — DURATION: 2 days

Due to: ____

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: C. E. Listenga, M. D. or other

Address: [illegible] Date signed: July 18, 1945

M

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Y

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH ★

07415

Reg. Diat. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) 70
2.(a) If veteran, name war

3.(a) FULL NAME Lillie G. Jones

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Dr. Paul Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 21 1865

8. AGE:

Years	Months	Days	If less than one day
79	10	18	hrs. ..... min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Alexander D. Irwin
13. Birthplace Pa.
MOTHER 14. Maiden name Elizabeth Todd
15. Birthplace Pa.
16. Informant Mrs. J. H. Collins Jr.
Address Snow Hill, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/45 (month) (day) (year)
Cemetery or crematory Presbyterian
Location Snow Hill, Md.
16. Funeral director Hearne & Downing
Address Snow Hill, Md.
16. 7/11 19 45 (Date rec'd by registrar) Reba Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 45 at 11:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 19 44 to July 9 19 45 and that I last saw h[illegible] alive on July 9 19 45

Immediate cause of death	DURATION
acute pulmonary Edema	1 Day
Due to Congestive Cardiac failure	10 days
Due to Cardiovascular Renal disease	10 yrs.
Other conditions Paralysis B. & L. Lower extremities	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert L. La Mar, MD M. D. or other
Address Snow Hill Date signed 7/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07416

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:
County [redacted] Worcester
City or town Berlin, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester
City or town Berlin Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William R. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married

6.(b) Name of husband or wife: Essie Jones
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1900

8. AGE:

Years	Months	Days	If less than one day
44	10	4	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: Isaac Jones
13. Birthplace: Md.

MOTHER
14. Maiden name: Sally Murray
15. Birthplace: Md.

16. Informant: Hazel Mumford
Address: Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1945 (month) (day) (year)
Cemetery or crematory: Sarah Dukes cemetery
Location: Bishop, Md.

18. Funeral director: Marguerite H. Watson
Address: Pocomoke City, Md.

19. 7-25 1945 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1945, to July 22 1945 and that I last saw h[illegible] alive on July 21 1945

	DURATION
Immediate cause of death: Coronary occlusion	1 hr.
Due to: Hypertensive Cardiovascular disease	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert S. Long M. D. or other
Address Frankford Del Date signed 7-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07417

Reg. Diat. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Near Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Near Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Madeline Kirk

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C	Married

6.(b) Name of husband or wife: Hoskins Kirk
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): Oct 30 1st, 1922

8. AGE: Years	Months	Days	If less than one day
22	9	30	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Elijah Lewis
13. Birthplace: Virginia

MOTHER
14. Maiden name: Alberta Bain
15. Birthplace: Virginia

16. Informant: Hoskins Kirk
Address: Pocomoke City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 5 1941 (month) (day) (year)
Cemetery or crematory: Ebernezer Baptist
Location: Exmore, Virginia
18. Funeral director: J. Edgar Thomas
Address: Accomac Virginia
19. Aug. 5 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1945, at 4:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocardial degeneration of heart	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John L. Riley Dep. Med. Exam. M. D. or other
Address: Brownsville Md. Date signed: 7/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

07418

CERTIFICATE OF DEATH

★ Reg. Diat. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: RURAL, Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: RURAL, Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No. #Rt. 3 (Welbourne)

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Addie Virginia Payne

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Stephen M. Payne

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): August 4, 1888

8. AGE: Years	Months	Days	If less than one day
56	11	16	..... hrs. ..... min.

9. Birthplace: Cobbs Island, NorthHampton + Va. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER

12. Name: Geo. W. Isdell

13. Birthplace: Birds Nest, Va.

MOTHER

14. Maiden name: Elizabeth Reynolds

15. Birthplace: Cobbs Island, Va

16. Informant: Stephen M. Payne

Address: Pocomoke City, Md. #Rt 3

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) July (day) 22 (year) 1945

Cemetery or crematory: Remson Cemetery

Location: Pocomoke City #Rt. 3

18. Funeral director: H. Harrison Bradshaw

Address: Pocomoke City, Md.

19. (Date rec'd by registrar) July 22 1945 Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945, to July 20 1945

and that I last saw h alive on July 15 1945

Immediate cause of death	DURATION
Chronic Interstitial	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Quigley M. D. or other

Address Pocomoke City, Md. Date signed 7-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

0741?

★ Reg. Dist. No. 955

1. PLACE OF DEATH:

County Worcester

City or town Berlin md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? big years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester

City or town Berlin md

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Willie Peal

3.(b) Social Security Number 239-12-8124

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	c c	no

6.(b) Name of husband or wife no

6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) about 1899

8. AGE: Years	Months	Days	If less than one day
about 76	—	—	....hrs. ....min.

9. Birthplace Worcester co. md

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Emma Kittrell

Address Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1945 (month) (day) (year)

Cemetery or crematory Round Tree

Location Worcester co.

18. Funeral director James F. Stewart

Address Salisbury md

19. 7-11-45 (Date rec'd by registrar) Helen F. Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations....

....Date of op....

Autopsy results....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.... Date of....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE Chas R. Lowe M. D. or other

Address Berlin md Date signed 7-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07420

CERTIFICATE OF DEATH

Reg. Dist. No. 351

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH: County Worcester
City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 85 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Emma Jane Purnell
3.(b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Oscar M Purnell
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan. 15 - 1860
8. AGE: Years 85 Months 6 Days 3 If less than one day ... hrs. ... min.
9. Birthplace Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Thomas Dixon Purnell
13. Birthplace Maryland
MOTHER 14. Maiden name Julia Ann Gray
15. Birthplace Maryland
16. Informant Mrs Julia P. Winder
Address 3541 N Meridian St Indianapolis Ind
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 45 (month) (day) (year)
Cemetery or crematory Presbyterian
Location Snow Hill, Md
18. Funeral director Hearne + Dennis
Address Snow Hill Md
19. 7/19 1945 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945 at 4:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1945, to July 18 1945 and that I last saw her alive on July 18 1945

Cause		DURATION
Immediate cause of death	Acute pulmonary Edema	2 days
Due to	Congestive Cardiac failure	2 wks
Due to	Senility	
Other conditions (Include pregnancy within 3 months of death)	Pharyngeal paralysis, Multiple vitamin deficiency, Hypertrophic Arthritis	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert C. La Mar, M.D. M. D. or other
Address Snow Hill Date signed 7/19/45

07421

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dint. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Worcester (WITHIN CORPORATE LIMITS)

City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Worcester

City or town Snow Hill Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Collins St (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME M. Ronnie Roxborough

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a a	Married

6.(b) Name of husband or wife Charles Roxborough (Don't forget maiden name)

Divorced 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 31, 1853

8. AGE: Years	Months	Days	If less than one day
92	3	1	..... hrs. ..... min.

9. Birthplace Accomac Va (Town, county, and state)

10. Usual occupation Housekeeping

11. Industry or business Same as above

12. Name of FATHER unknown

13. Birthplace unknown

14. Maiden name of MOTHER Pine Jack

15. Birthplace Accomac Va

16. Informant Ellen Pingle

Address Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 1945 (month) (day) (year)

Cemetery or crematory Ebenezer

Location Snow Hill Md

18. Funeral director Jesse E Stewart

Address Salisbury Md

19. 7/5/45 (Date rec'd by registrar) Reday Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945 at 8 35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 to July 1, 1945

and that I last saw h[illegible] alive on July 1, 1945

Immediate cause of death	DURATION
Cerebral Apoplexy	8 days
Due to Hypertension	5 years
Due to	
Other conditions Myocarditis	3 years

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE G. H. Stengle M.D. (M. D. or other)

Address Salisbury Md Date signed 7/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

67422

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Near Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 7 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Near Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Lee Scott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col'd	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 13, 1942

8. AGE:

Years	Months	Days	If less than one day
2	7	0	hrs. min.

9. Birthplace: Pocomoke Rt 2 # Worcester - Md

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name: Major Scott

13. Birthplace: Philadelphia Pa

MOTHER 14. Maiden name: Odessa Brittingham

15. Birthplace: Pocomoke City Md

16. Informant: Lloyd Brittingham

Address: # Rt 2 Pocomoke City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1945 (month) (day) (year)

Cemetery or crematory: St. James Cemetery

Location: Rur 2 Pocomoke Md.

18. Funeral director: N. Harrison Bradshaw

Address: 401 Market St. Pocomoke Md

19. July 16 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Burned to dest by fire — DURATION: Few Minutes

Due to: House burning with Lire in it.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of July 13 '45

Where did injury occur? Near Pocomoke City (City or town) Worcester (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Burned by fire Injured at work? no

23. SIGNATURE: John L. Riley Dep. Med Exam M. D. or other

Address: Snow Hill Md. Date signed 7/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

CERTIFICATE OF DEATH

07423

Reg. Dist. No. 855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Worcester

City or town Walltonville Md. or Whaleysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Worcester

City or town Walltonville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Whaleyville, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha A. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10. 1945

8. AGE:

Years	Months	Days	If less than one day
Whaleyville		1	..... hrs. ..... min.

9. Birthplace Walltonville Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Joseph Smith

13. Birthplace Wellen Va.

MOTHER 14. Maiden name Helen Bernell

15. Birthplace Berlin Md.

16. Informant Joseph Smith

Address Dagsboro Del.

17. B. (Burial, cremation, or removal. Which?) Date thereof July 11 1945 (month) (day) (year)

Cemetery or crematory Germantown

Location Berlin Md.

18. Funeral director Salvatore N. Watson

Address Frankford Del.

19. 7-11- 1945 Helen I. Hayward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11th 1945 at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945, to July 11 1945

and that I last saw h.... alive on July 11 1945

Immediate cause of death Cerebral hemorrhage — DURATION 1 day

Due to birth

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. F. Saccall M. D.
M. D. or other

Address Berlin Md. Date signed 7/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

17424

★Reg. Diat. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)
Street No. Laurel
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Henry Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Lillie B. Taylor

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 18, 1875

8. AGE: Years	Months	Days	If less than one day
70	4	5	...hrs. ...min.

9. Birthplace Gratons Accomac, Va
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Angelo Taylor
13. Birthplace Va

MOTHER
14. Maiden name Mahalia Smith
15. Birthplace Va

16. Informant Miss Blanche Taylor
Address Pocomoke city, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1945 (month) (day) (year)
Cemetery or crematory Downings
Location Oak Hall, Virginia

18. Funeral director Margarette H. Watson
Address Pocomoke city, Md.

19. July 25 1945 Ann E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct 1944 to July 23 1945
and that I last saw h... alive on July 23 1945

Immediate cause of death	DURATION
Due to Carcinoma Stomach	18 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. E. Justice M. D. or other
Address Pocomoke City Md Date signed 7/27/45

07425

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 351

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION) 70
2.(a) If veteran, name war

3.(a) FULL NAME Grace Victor

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

8.(b) Name of husband or wife John Victor
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Dec. 10 - 1895

8. AGE:

Years	Months	Days	If less than one day
49	7	9	...hrs. ...min.

8. Birthplace Snow Hill Worcester Co. Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Ruffus Collins
13. Birthplace Maryland
MOTHER 14. Maiden name Mr Brown
15. Birthplace
18. Informant John Victor
Address 822 Walnut St. Wilmington Del.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23/45 (month) (day) (year)
Cemetery or crematory Bethel
Location Snow Hill Md
18. Funeral director Deane & Timmis
Address Snow Hill Md
19. 7/24 1945 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945 at 4:05 P.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 5 1945 to July 19 1945 and that I last saw h...alive on July 10 1945

	DURATION
Immediate cause of death Pulmonary TBc	5 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. H. Kemble M.D. M. D. or other
Address Salisbury Md Date signed 7/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

07426

CERTIFICATE OF DEATH ★

Reg. Dist. No. 351

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County Worcester

City or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Ernest C. Wist

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hettie West

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb 9 1875

8. AGE: Years	Months	Days	If less than one day
70	5	0	hrs. min.

9. Birthplace Snow Hill, Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name John Wist

13. Birthplace Snow Hill

MOTHER

14. Maiden name Mary Chatam

15. Birthplace Snow Hill. Md

16. Informant Otis Wist

Address Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13/45 (month) (day) (year)

Cemetery or crematory Baptist

Location Snow Hill Md

18. Funeral director Hearne & Dunnock

Address Snow Hill Md

19. 7/11 (Date rec'd by registrar) 19 45 LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 45 at 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	1 Hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? No

23. SIGNATURE John L. Riley D.P.M. Examining M. D. or other

Address Snow Hill (Md) Date signed 7/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (154)

CERTIFICATE OF DEATH

★ 07427

Reg. Diat. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 400 Bank Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dorothy Virginia Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 6, 1945

8. AGE: Years	Months	Days	If less than one day
			1½ hrs. ..... min.

9. Birthplace: Pocomoke-Worcester, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Stanford Jester

13. Birthplace: Temperanceville, Va.

MOTHER — 14. Maiden name: Jennie Louise Williams

15. Birthplace: Corpeake, N. C.

16. Informant: James Williams (grandfather)

Address: 400 Bank St., Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7, 1945 (month) (day) (year)

Cemetery or crematory: Hall's Hill Cemetery

Location: Pocomoke City, Md.

18. Funeral director: James Williams (grandfather)

Address: 400 Bank St., Pocomoke City, Md.

19. July 7, 19 45 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 19 45, at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Premature - 7 months	
This baby lived only	
Due to 1½ hours according to	
information given by the	
Due to Grandfather, James Williams	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: R. H. Lawson M.D. Health Officer

M. D. or Coroner

Address: Pocomoke City, Md. Date signed: July 7 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15